A Model for Opioid Risk Stratification

Assessing the Psychosocial Components of Orofacial Pain

Ronald J. Kulich, PhD[a,b,1,*], Jordan Backstrom, MDiv, PsyD[c,2], Jennifer Brownstein, MA[a,b,1,*], Matthew Finkelman, PhD[d,*], Shuchi Dhadwal, DMD[a,3,*], David DiBennedetto, MD, DABPM[e,2]

KEYWORDS

• Opioid • Risk-management • Dentistry • Substance abuse • Interprofessional

KEY POINTS

- Deaths related to opioid abuse continue to be a national epidemic, with diversion and nonmedical use of prescription medications often occurring as a result of prescriptions written for acute pain by dentistry.
- Dentists are assuming increased responsibilities in the public health arena and now play an important role in the judicious monitoring of the dispensing of controlled substances.
- Dentists also now are in a position to use formal screening strategies for the patient at risk for substance abuse, an important role in risk mitigation.
- After assessing risk, the dentist's responsibilities include counselling the patient, referral, and close collaboration with cotreating physician colleagues.

In the last 20 years, there is evidence of increasing deaths due to overdose because controlled substances are more widely available.[1] Dentistry has been particularly affected by the national crisis in opioid abuse. Dentistry, largely as a result of analgesic prescriptions for surgical procedures, had been identified as the second highest opioid prescriber group. There has been an overall drop in opioid prescribing by dentists, largely due to a combination of continuing educational efforts and emphasis from the general media on the apparent risks.[2] An especially important tool in mitigating this risk is the psychosocial assessment. Nonetheless, evidence of more judicious screening for the high-risk patient and counseling or referral for substance abuse care remains lacking.

Disclosure Statement: All authors have nothing to disclose.

[a] Department of Diagnostic Sciences, Craniofacial Pain and Headache Center, Tufts School of Dental Medicine, Boston, MA, USA; [b] Department of Anesthesia, Critical Care and Pain Medicine, Massachusetts General Hospital, Harvard Medical School, Boston, MA, USA; [c] Boston Pain Care Center, Waltham, MA, USA; [d] Department of Biostatistics and Experimental Design, Tufts University School of Dental Medicine, 1 Kneeland Street, 7th Floor, Boston, MA 02129, USA; [e] Department of Diagnostic Sciences, Boston Pain Care, Tufts School of Dental Medicine, Boston, MA, USA

[1] Present address: 15 Parkman St, Boston, MA 02114.

[2] Present address: 85 First Avenue, Waltham, MA 02451.

[3] Present address: 1 Kneeland Street, 7th Floor, Boston, MA 02129.

* Corresponding authors. 1 Kneeland Street, 6th Floor, Boston, MA 02129.

E-mail address: rkulich@mgh.harvard.edu

Oral Maxillofacial Surg Clin N Am 28 (2016) 261–273
http://dx.doi.org/10.1016/j.coms.2016.03.006

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As interdisciplinary clinics and research programs become more common, the practice of implementing a psychosocial assessment as part of a comprehensive care plan has become the standard of care. This change has developed in parallel with the general recognition that patients presenting with orofacial pain experience higher levels of psychological distress and have more psychiatric comorbidities than other dental patient populations.[3,4] Patients with temporomandibular disorders often endorse depressed mood, anxiety, and posttraumatic stress disorder at rates significantly higher than controls.[5] Indeed, the literature has developed sufficiently now to demonstrate a clear etiologic link between psychological factors and problems of the masticatory muscles, the temporomandibular joint, and associated physiologic structures.[6] Specifically, the psychological factors of personality traits, stress reactivity, somatic focus, and the tendency toward catastrophizing, have an exacerbating influence on myofascial pain and increase the risk of chronic painful temporomandibular disorders.[6] Yet, even as the presence and expectation of psychosocial assessment in the orofacial pain setting becomes more ubiquitous, the dual function, both as a diagnostic instrument in holistic patient care and as a tool for risk assessment, remains confused, particularly in the context of opioid prescribing.

Traditionally, the central components of the assessment have included[7]

- Patient rapport building
- Acquisition of medical and psychiatric history with identification of recent medical changes and life stressors
- Exploration of the patient's lifestyle such as diet, exercise, and social support
- Current level of function
- Any relevant legal issues
- A mental status examination with suicide risk assessment and exploration of any substance use disorder.

Although all these areas remain central to the provision of a quality psychosocial assessment, the assessment rubric must be flexible and organized under the conceptual primacy of opiate risk if these medications could potentially be part of the orofacial pain patient's overall treatment plan. This article describes a way forward, emphasizing both quality patient care and a method of risk-mitigation for the dentists and pain specialists who provide that care.

The scope of the opioid problem dates to the mid-1990s, when adequate treatment of acute and chronic pain was identified as an international public health concern. Multiple international health care agencies identified access to pain care as part of the problem, with debate in the United States continuing as to whether there has been any clear progression.[8,9] It is argued that there needs to be a balance between risk mitigation and access to effective analgesic use for the patient with pain.[10] The widely disseminated Institute of Medicine report, *Relieving Pain in America*, highlights issues of access with its first principle, "Effective pain management is a moral imperative, a professional responsibility, and the duty of people in the healing professions."[11(pp3)] Despite this attention, concern about opioid abuse, diversion, and the increasing number of opioid-related deaths persist.

Diversion of prescription medications has also been recognized as a growing problem. For example, individuals with substance abuse issues often obtained their medication from family members and friends. In a survey of dental patients, Ashrafioun and colleagues[12] (2014) found that approximately 5% to 10% of patients reported that in the past 30 days they sometimes or rarely took someone else's medications. Although diversion may seem to involve relatively few patients within a dental practice, the high volume of patients seen in dentistry underscores the magnitude of the problem. By 2010, 81.6% of individuals ages 12 years and older who used opioids illicitly were obtaining them from a friend or relative, with 54.2% obtaining it without a monetary fee. By 2011, 52 million people in the United States ages 12 years and older used prescription drugs, nonmedically, 1 or more times in their lifetime. Of these individuals, more than 6% were found to be using prescription drugs illicitly within the prior month.[13]

As opioid-related deaths increased concurrent with an increase in sales, the pharmaceutical industry and prescribers were considered largely responsible. Among the most common drugs implicated in deaths were the short-acting analgesics, including hydrocodone and oxycodone, with methadone being a particular risk when prescribed for pain. Dentists were writing prescriptions for 1 to 1.5 billion doses of immediate opioids per year, only exceeded by primary care physicians and internists.[14,15] Deaths were also attributed to polypharmacy, with benzodiazepines significantly adding to the risk. Drug overdose became the leading cause of death, exceeding motor vehicle accidents in many states.[16]

Dentistry began to respond to the public health crisis. Levy and colleagues[17] (2015) found that the largest drop in percentage of prescribing from 2007 to 2012 was from emergency medicine